Bedford South Dentistry
love your smile
15 Peakview Way Unit 300, Bedford South, NS, B3M 0G2
4-DENTAL(433-6825) www.bedfordsouthdentistry.com

Patient Information – 16+

PATIENT NAME (first, middle, last) ______________________________

PREFERRED NAME______________ **MARITAL STATUS**__________ **HEALTH CARD #**______________

PATIENT'S date of birth (D/M/Y) ______________**AGE** ______ **GENDER** _________ **PREF. PRONOUNS** ______________

PATIENT'S FULL ADDRESS______________________________

Phone C ______________ **H** ______________ **W** ______________

EMERGENCY CONTACT______________________________

EMAIL ______________________________ **PREFERRED CONTACT METHOD** ______________

Please indicate why you chose our office (i.e. friend recommendation, Internet, location, family, etc.)

____

Insurance Information

COMPANY ______________**PLAN/GROUP#**______________ **CERT/ID#**______________

NAME and date of birth of PLAN HOLDER ______________________________

RELATIONSHIP TO PLAN HOLDER ______________ (Provide secondary insurance plan information to receptionist)

Medical Information

Are you generally in good health?	Yes	No	______________
Have there been any changes in general health within the year?	Yes	No	______________
Are you now under physician care?	Yes	No	______________
Have you ever had a serious illness or operation?	Yes	No	______________
Have you been hospitalized within the past 5 years?	Yes	No	______________
Do you have an infectious or communicable disease?	Yes	No	______________

RESPIRATORY SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Tuberculosis	Sinusitis or sinus trouble	Emphysema
Bronchitis	Asthma	Shortness of breath

CARDIOVASCULAR SYSTEM: Please indicate if you have, or have ever had, any of the following: (circle)

Heart trouble	Heart attack	Stroke	Congenital heart disease
Chest pains	Angina pectoris	Endocarditis	Rheumatic heart disease
Arteriosclerosis	Heart palpitations	Low blood pressure	High blood pressure
Cardiac pacemaker	Damaged heart valves	High cholesterol	Jaundice
Blood disorders	Anemia/Sickle cell	Hemophilia	Bruise easily
Abnormal bleeding			

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Last blood pressure reading: ____________________ **Date:** ____________________

CENTRAL NERVOUS SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Epilepsy or other seizures	Numbness or tingling sensations	Head trauma	Bipolar disorder
Depression	Schizophrenia	Emotional disturbances	Concussion
Neurological disorder	Anxiety	Eating disorder	Fainting spells
Autism spectrum	ADHD	PTSD	

Other mental disorder ____

GASTROINTESTINAL SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Kidney/bladder problems	Liver disease	Stomach ulcers
Irritable bowel syndrome	Crohn's or colitis	Celiac

ENDOCRINE SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Diabetes	Hypothyroidism	Hyperthyroidism

SKELETAL SYSTEM: Please indicate if you have or have ever had any of the following: (circle)

Osteoarthritis	Rheumatoid arthritis	Bone infection	Implants
Bone density issues	Osteoporosis	Temporomandibular joint disorder	Artificial joints
History of broken bones	Osteopenia	Dysfunction	____________________

NEOPLASMS: Please indicate if you have or have ever had any of the following:(circle)

Cancer, tumour or malignancy ____________________ Chemotherapy or radiation therapy ____________________

INFECTION OR COMMUNICABLE DISEASE: Please indicate if you have or have ever had any of the following: (circle)

Sexually-transmitted diseases	Creutzfeldt-Jakob disease	HIV/AIDS
Hepatitis	Rheumatic fever	Other Transmissible Spongiform Encephalopathy

INFORMATION TO MAKE YOUR APPOINTMENTS BETTER: Do you have any of the following: (circle)

Trouble hearing	Trouble seeing	History of ear, nose, and throat problems
Persistent thirst	Severe headaches	Can't lie down all the way
Difficulty swallowing	Acid reflux	Recent change of appetite
Frequent vomiting	Extra pillows to sleep	Urinate more than 6 times per day
Headaches	Sinus troubles	Tendency to faint
Hard to freeze	Jaw stiffness	

REPRODUCTIVE HEALTH: Indicate if any of the following applies to you: (circle)

Pregnant	Nursing	Birth control pills	Hormonal therapy	Post-menopausal

Medical doctor ____________________ **Phone:** ______________ **Last medical exam?** ______________

Previous dentist ____________________ **Phone:** ______________ **Last dental exam?** ______________

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MEDICATIONS:
Please list prescription **AND** non-prescription medications (or provide list from pharmacy)

____

____

ALLERGIES:
Please list all allergies or adverse reactions to **ANY** substance. Examples: local anesthetics, antibiotics, aspirin, ibuprofen, naproxen, other NSAIDS, Tylenol, narcotics, sulfa drugs, codeine, latex, nickel/other metals, foods

____

____

OTHER: Is there anything else concerning your health that you think the dentist should know about?

____

____

Dental Questionnaire

Question	Yes		No		
Do you have any discomfort or pain in your mouth?	Yes	☐	No	☐	______
Are you able to eat and chew foods satisfactorily?	Yes	☐	No	☐	______
Do you have any problems with your jaw joints?	Yes	☐	No	☐	______
Do you have any problems with your bite?	Yes	☐	No	☐	______
Have you had problems with previous dental treatment?	Yes	☐	No	☐	______
Do you experience tooth sensitivity to cold or hot liquids?	Yes	☐	No	☐	______
Are you satisfied with the appearance of your teeth?	Yes	☐	No	☐	______
Are you happy with the colour of your teeth?	Yes	☐	No	☐	______
Are you interested in discussing bleaching options?	Yes	☐	No	☐	______
Are you interested in discussing teeth-straightening options?	Yes	☐	No	☐	______
Are you interested in discussing cosmetic dentistry options?	Yes	☐	No	☐	______

Do you do any of the following? (circle)

Drink tea	Drink coffee	Drink alcohol	Smoke tobacco	Use cannabis
Grinding/clenching	Snoring	Thumb-sucking	Chew fingernails	Recreational drugs

Do you currently have or have you ever had in the past: (circle)

Facial pain	Sleep apnea	Jaw Pain	Headaches
Bleeding gums	Sensitive teeth	Earaches	Neck Pain
Braces	Invisalign	Retainers	Mouth guard
Biteplane/night guard	Dentures/Partials	Crowns/bridges	Implants

For the following questions, please check the response that best describes your situation:

1. I usually go to the dentist every:

☐ 3-4 months ☐ 6-12 months ☐ a year or more between visits ☐ I only go when I'm in pain

2. I routinely use the following dental products:

Manual toothbrush:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Electric toothbrush:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Dental floss:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never
Mouthwash:	☐ Two or more times a day	☐ Once a day	☐ Three times a week	☐ Rarely	☐ Never

3. I suffer from dental anxiety (circle): Not at all Mild Moderate Severe

4. Which one of the following situations best describes your attitude toward treatment?

☐ I am willing to do whatever it takes to save a tooth.
☐ My decision to save a tooth relies heavily on what it costs and the time commitment required.
☐ My decision to save a tooth relies heavily on whether it is covered by insurance.
☐ I would rather have it extracted.

Any other concerns/anything else you'd like us to know? ____

Authorization and Consent

______To the best of my knowledge, the medical and dental history provided herein is correct.

______ I consent to advisable and necessary dental procedures, medications or anesthetics, to be administered by the attending dentist or by her supervised staff, during the performance of diagnostic tests or dental treatments.

______I authorize the dentist to release information to other healthcare practitioners and insurance carriers. If there is a specific person(s) who should <u>not</u> receive my dental records, name them: ____

______If I did not receive an estimate, it is my duty to request one. I understand that occasionally it may be necessary to modify a treatment and the fees associated with that treatment.

______I understand that I am financially responsible for ALL services and procedures, and that payment-in-full is expected on the day of each dental visit. Claims are submitted online, and benefits from insurance will be paid to you.

______If for unforeseen circumstances, my bill is not paid in full, then I must leave a credit card number for final payment.

______I understand that the dentist and staff do not know the details of individual or group dental plans and cannot access this information due to privacy regulations; patients must understand their own insurance.

______I understand that a charge of $102 will apply for failure to attend a pre-booked appointment or for failure to provide at least 48 hours' notice (2 business days) for schedule changes.

CONSENT FOR X-RAYS
In providing the best possible dental care for you, we may need to use radiographs (x-rays) to help us with proper diagnosis. We may need combinations of panoramic, bitewing, periapical or occlusal x-rays to maximize our ability to diagnose conditions in the mouth that are only visible with x-rays. Our goals are to keep your radiation exposure as low as reasonably achievable. Dental x-rays provide minimal radiation exposure and valuable information necessary for your health. For this reason, our doctors will only recommend x-rays which they feel are necessary to keep you in optimal health. All of our equipment is maintained and inspected regularly for optimum performance and safety. Use of x-rays will help to identify the following conditions: periodontitis, abscesses, cysts, abnormal anatomy, impacted teeth, extra teeth, resorption of bone, resorption of teeth, fractured teeth, fractured bone, TMJ disorder, abnormal growth, pathology (benign or malignant), and dental cavities. The benefit we receive from x-rays far outweighs the minimal risks associated with it. You have the option to refuse x-rays which renders our examination to a limited visual exam.

______Yes, I agree and accept dental x-rays

______No, I voluntarily refuse to get x-rays for proper diagnosis. I understand that this is against medical advice and will significantly hinder the dentist from properly diagnosing conditions I may have. I will not hold the doctor or the practice liable for any failure to diagnose or improper treatment choices that are initiated as a direct result of lack of x-ray information.

Signature: ____________________________________ Date: _______________________________

CONSENT FOR LOCAL ANESTHESIA
The goal of the local anesthetic is to lessen or eliminate pain during the dental treatment. This consent form is designed to make you aware of the following risks involved with local anesthetics. These include, but are not limited to:

- At the time of injection: dizziness, vomiting, nausea, increase in heart rate, allergic reactions, syncope.
- Noted sometime after the injection: discoloration, bruising, headache, tenderness at the site of injection. It is also possible for people to injure themselves (bite) while they are numb and cause damage to their cheeks, lips, tongue.
- Injury to nerves can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums, or tongue. This may persist for weeks, months, years or very rarely, permanent.

It is normal for the numbness experienced by local anesthetic to take time to wear out. For upper jaws, expect 1-2 hours after your procedure and for lower jaws, 4-6 hours would be considered within the normal range. It is rare, but some people may remain numb for longer than expected. In extremely rare cases, this can be permanent.

I will be given the opportunity to ask additional questions about local anesthesia before appointments.

Signature: _____________________________________ Date: ______________________________

Patient/guardian sign and date: _________________________________Print: ________________________________

Dentist signature and date: ____

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Dr. Natalie Brothers Dr. Jillian Reynolds Dr. Bonnie Theriault Dr. Allison Thibault

E-mail: reception@bedfordsouthdentistry.com

Patient Records Consent Form

Patient First Name: ____________________________ **Patient last name:** ____________________________

Patient Date of Birth: ____________________________

Transfer of records from:

Previous dentist: ____

Address: ____

Fax number: ____

E-mail address:
(even better! ☺) ____

I hereby give authorization to release a copy of my dental records to Bedford South Dentistry.

Patient signature: ____

Date: ____

The following to be completed by the previous dental office:

The above patient has come to our office for continuing dental care. Kindly forward dental information with recent radiographs and chart notes. *****IF YOU ARE ABLE, PLEASE SEND X-RAYS IN DEXIS FORMAT*****

Date of last complete oral exam:	
Date of last bitewing radiographs:	
Date of last Panorex radiograph:	
Date of last recall exam:	
Date of last hygiene appointment:	